

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4905
CERTIFICATE OF DEATH

04896

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 118 Clyde Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HAZEL Middle RUTH Last BOZMAN		4. DATE OF DEATH Month APRIL Day 26th Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 19, 1903
9. AGE (In years last birthday) 56 yrs.		10. IF UNDER 1 YEAR Months 2 Days 7 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee - Shirt Factory		10b. KIND OF BUSINESS OR INDUSTRY Somerset Co. Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME James W. Warwick		14. MOTHER'S MAIDEN NAME Beulah Dodson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Evelyn Wallace (Daughter)		Address 118 Clyde Ave Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Esophagus 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 2 1/2 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1953 to April 1959 , that I last saw the deceased alive on April 26, 1959 , and that death occurred at 7:00 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Alberta Mattax		DATE SIGNED Apr. 28 / 1959	
PHYSICIAN'S NAME (Type) Dr. Alberta Mattax		ADDRESS (Street, city or town, state) Camden Ave. Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 28, 1959	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR MAY 1 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4907

Item 7 Film 6242 5-20-59 et

CERTIFICATE OF DEATH

04897

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>Accomac</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>RURAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL New Church</u>		d. STREET ADDRESS <u>83X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA (GENERAL Hospital)</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Perry ALFRED BRIMER</u>				4. DATE OF DEATH Month Day Year <u>April 7th 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/21/1895</u>	9. AGE (In years lost birthday) <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FARMING</u>		11. BIRTHPLACE (State or foreign country) <u>MAKEMIE PARK U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALFRED</u>				14. MOTHER'S MAIDEN NAME <u>BRIMER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>228-48-5292</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion, Acute</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <u>Arteriosclerotic Cardiovascular Disease</u> ? (c)				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Lung</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 5, 1959</u> , to <u>April 7, 1959</u> , that I last saw the deceased alive on <u>April 7, 1959</u> , and that death occurred at <u>10:00</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rufus S. Gardner, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>PINEBLUFF Rd. SALISBURY, Md.</u>			
PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR.</u>				DATE SIGNED <u>4/9/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>DOWNINGS</u>		22d. LOCATION (City, town, or county) (State) <u>OAK HALL VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>For FUNERAL Home</u>				ADDRESS <u>TEMPERANCE-VILLE VA.</u>		24a. REC'D BY REGISTRAR <u>DATE APR 17 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>							

MEDICAL CERTIFICATION

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082

1

Page 4

1840

CERTIFICATE OF DEATH

1840

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4908

CERTIFICATE OF DEATH

Reg. Dist. No.

04898

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 1 month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Harry Middle H. Last Bromwell		4. DATE OF DEATH Month April Day 17 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/14/1881
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during WATERMAN life, even if retired) ?		10b. KIND OF BUSINESS OR INDUSTRY SEAFOOD	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Bromwell		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) ? INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 16 , 19 59 , to April 17 , 19 59 , that I last saw the deceased alive on April 17 , 19 59 , and that death occurred at 3:48 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 4/17/59 ACTUAL SIGNATURE L. V. Maldve M.D. Salisbury, Maryland PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.			
22a. BURIAL, CREMATION, or other disposition (Specify) BURIAL		22b. DATE THEREOF APRIL 20 1959	
22c. NAME OF CEMETERY OR CREMATORY EAST NEW MARKET CEM.		22d. LOCATION (City, town, or county) (State) EAST NEW MARKET MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE LECOMPTE FUNERAL SERVICE		24b. REGISTRAR'S SIGNATURE Arthur E. Thoma	
ADDRESS CAMBRIDGE MARYLAND.		24c. REC'D BY REGISTRAR DATE APR 22 '59	

04899

4909

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>3 Days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>1229 Middle Blvd.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Infant</u> Middle <u>Son</u> Last <u>Burton</u>				4. DATE OF DEATH Month <u>April</u> Day <u>19</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/17/59</u>	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> Hours <u>33</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>O.J. Burton</u>				14. MOTHER'S MAIDEN NAME <u>Lillianne Dickson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>None</u>		INFORMANT Address <u>Mr. O.J. Burton, Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Emboli (Post Exchange Transfusion)</u> <u>770.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Hemolytic Disease of Newborn due to Rh factor</u> DUE TO (c) <u>33 hrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>4/17</u> , 19 <u>59</u> , to <u>4/19</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/19/59</u> , 19 <u>59</u> , and that death occurred at <u>11:10 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>4/19/59</u>							
ACTUAL SIGNATURE <u>Alfred C. Kolls</u> M.D. <u>Salisbury, Maryland</u>							
PHYSICIAN'S NAME (Type) <u>Alfred C. Kolls 411 West College Ave., Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		22b. DATE THEREOF <u>4/23/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>J. William Lee's Crematory</u>		22d. LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u>				ADDRESS <u>4</u>		24a. REC'D BY REGISTRAR <u>APR 23 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Carlton L. Brand</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

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2082284XV2 Mary D. Baker

1880

CERTIFICATE OF DEATH

1880

Johnston

Johnston

Mr. J. A. Johnston, Jr.

John

John

1880

Johnston, John

Johnston, John

Johnston, John

Johnston, John

Johnston, John

4910

CERTIFICATE OF DEATH

04900

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XXXXXXXXXX Salisbury		c. LENGTH OF STAY IN 1b 6 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 810 East Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Thomas E. Butler		4. DATE OF DEATH Month 4 Day 8 Year 19 59	
5. SEX Male	6. COLOR OR RACE AA	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-14-1891
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister		10b. KIND OF BUSINESS OR INDUSTRY Clergical	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William E. Butler	
14. MOTHER'S MAIDEN NAME Alice Nickles		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 215 12 2175		17. INFORMANT Mrs. Thomas Butler, 810 East Rd., Salisbury, Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X DUE TO Cerebrovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Arterio- sclerosis (c) sclerosis		INTERVAL BETWEEN ONSET AND DEATH 2 months Indefinite	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-7-59 to 8-9-59 , that I last saw the deceased alive on 8-6-59 , 19 59 , and that death occurred at 10 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE E. A. Purnell		ADDRESS (Street, city or town, state) 622 N. Main	
PHYSICIAN'S NAME (Type) E. A. Purnell, M. D.		DATE SIGNED 10-9-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/11/1959	22c. NAME OF CEMETERY OR CREMATORY Federal Hill	22d. LOCATION (City, town, or county) (State) Federalburg, Md
23. FUNERAL DIRECTOR'S SIGNATURE J.F. Stewart Funeral Home, Salisbury, Md		24a. REC'D BY REGISTRAR DATE APR 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1910

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
MRS. J. M. JONES		F		45		JAN. 15, 1865		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		PERIOD OF ILLNESS		PLACE OF DEATH	
1234 E. BALTIMORE ST.		HOUSEWIFE		HEART DISEASE		2 WEEKS		HOME	
DATE OF DEATH		TIME OF DEATH		PLACE OF INTERMENT		NAME OF MINISTER		NAME OF FUNERAL HOME	
JAN. 20, 1910		10:30 A.M.		CATHOLIC CHURCH		FATHER J. J. JONES		J. J. JONES & SONS	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF MINISTER		SIGNATURE OF FUNERAL HOME		SIGNATURE OF REGISTRAR	
DECEASED'S SIGNATURE		WITNESSES' SIGNATURES		MINISTER'S SIGNATURE		FUNERAL HOME'S SIGNATURE		REGISTRAR'S SIGNATURE	
DECEASED'S ADDRESS		WITNESSES' ADDRESSES		MINISTER'S ADDRESS		FUNERAL HOME'S ADDRESS		REGISTRAR'S ADDRESS	
DECEASED'S OCCUPATION		WITNESSES' OCCUPATIONS		MINISTER'S OCCUPATION		FUNERAL HOME'S OCCUPATION		REGISTRAR'S OCCUPATION	
DECEASED'S RELIGION		WITNESSES' RELIGIONS		MINISTER'S RELIGION		FUNERAL HOME'S RELIGION		REGISTRAR'S RELIGION	
DECEASED'S RACE		WITNESSES' RACES		MINISTER'S RACE		FUNERAL HOME'S RACE		REGISTRAR'S RACE	
DECEASED'S COLOR		WITNESSES' COLORS		MINISTER'S COLOR		FUNERAL HOME'S COLOR		REGISTRAR'S COLOR	
DECEASED'S SEX		WITNESSES' SEXES		MINISTER'S SEX		FUNERAL HOME'S SEX		REGISTRAR'S SEX	
DECEASED'S AGE		WITNESSES' AGES		MINISTER'S AGE		FUNERAL HOME'S AGE		REGISTRAR'S AGE	
DECEASED'S DATE OF BIRTH		WITNESSES' DATES OF BIRTH		MINISTER'S DATE OF BIRTH		FUNERAL HOME'S DATE OF BIRTH		REGISTRAR'S DATE OF BIRTH	
DECEASED'S PLACE OF BIRTH		WITNESSES' PLACES OF BIRTH		MINISTER'S PLACE OF BIRTH		FUNERAL HOME'S PLACE OF BIRTH		REGISTRAR'S PLACE OF BIRTH	
DECEASED'S DATE OF DEATH		WITNESSES' DATES OF DEATH		MINISTER'S DATE OF DEATH		FUNERAL HOME'S DATE OF DEATH		REGISTRAR'S DATE OF DEATH	
DECEASED'S TIME OF DEATH		WITNESSES' TIMES OF DEATH		MINISTER'S TIME OF DEATH		FUNERAL HOME'S TIME OF DEATH		REGISTRAR'S TIME OF DEATH	
DECEASED'S PLACE OF DEATH		WITNESSES' PLACES OF DEATH		MINISTER'S PLACE OF DEATH		FUNERAL HOME'S PLACE OF DEATH		REGISTRAR'S PLACE OF DEATH	
DECEASED'S NAME OF FUNERAL HOME		WITNESSES' NAMES OF FUNERAL HOMES		MINISTER'S NAME OF FUNERAL HOME		FUNERAL HOME'S NAME OF FUNERAL HOME		REGISTRAR'S NAME OF FUNERAL HOME	
DECEASED'S NAME OF MINISTER		WITNESSES' NAMES OF MINISTERS		MINISTER'S NAME OF MINISTER		FUNERAL HOME'S NAME OF MINISTER		REGISTRAR'S NAME OF MINISTER	
DECEASED'S NAME OF REGISTRAR		WITNESSES' NAMES OF REGISTRARS		MINISTER'S NAME OF REGISTRAR		FUNERAL HOME'S NAME OF REGISTRAR		REGISTRAR'S NAME OF REGISTRAR	

4911

CERTIFICATE OF DEATH

04901

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				/d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>First</u> <u>Hazold</u> <u>Middle</u> <u>Briscoe</u> <u>Last</u> <u>Causey</u>				4. DATE OF DEATH <u>Month</u> <u>April</u> <u>Day</u> <u>20</u> <u>Year</u> <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/13/1901</u>	
9. AGE (In years lost birthday) <u>57</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u>7</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Boat Railway</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Henry Briscoe</u>				14. MOTHER'S MAIDEN NAME <u>Annie Murray</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>-----</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Howard Gordy, Sr., Salisbury, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY INSUFFICIENCY</u> DUE TO (c) <u>ATHEROSCLEROSIS</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 HOURS</u> <u>4 YEARS</u> <u>4 YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>5 MAY 1947</u> to <u>20 APRIL 1959</u> , that I last saw the deceased alive on <u>20 APRIL 1959</u> , and that death occurred at <u>4:50 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Nanticoke, Md.</u> DATE SIGNED <u>4/22/59</u>							
ACTUAL SIGNATURE <u>Richard H. Saunders</u> M.D.				PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u> <u>Nanticoke, Maryland</u> <u>4/22/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/22/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Turners Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Nanticoke, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. P. Bivale</u> ADDRESS <u>Bivale, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>APR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4912

CERTIFICATE OF DEATH

04902

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>5 hours</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> <u>23X-2</u> d. STREET ADDRESS <u>N. MAIN ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Alonzo P. Christopher</u> First Middle Last 4. DATE OF DEATH <u>April 25 1959</u> Month Day Year		5. SEX <u>male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>SEPT 18, 1883</u> <u>75</u> yrs. 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED MAYOR</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>SELF-EMPLOYED</u> 11. BIRTHPLACE (State or foreign country) <u>DENTON MO</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN J. CHRISTOPHER</u> 14. MOTHER'S MAIDEN NAME <u>ANNIE TOYERS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>NO</u> INFORMANT <u>Mrs. A. P. CHRISTOPHER</u> Address <u>BERLIN MD</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Coronary Occlusion</u> DUE TO <u>Acute Posterior Myocardial Infarction</u> (b) <u>Coronary Artery Disease</u> DUE TO <u>Arteriosclerotic Cardiovascular Dis.</u> (c) <u>?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>?</u> INTERVAL BETWEEN ONSET AND DEATH <u>Instantaneous</u> <u>1 hr.</u> <u>3 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>4/25</u> , 19 <u>59</u> , to <u>4/25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/25</u> , 19 <u>59</u> , and that death occurred at <u>4:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, State) <u>PINEBLUFF RD. 4/25/59</u> DATE SIGNED <u>4/25/59</u>	
ACTUAL SIGNATURE <u>Rufus S. Gardner</u> M.D. PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER, JR. SALISBURY, MD.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>4/28/59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u> 22d. LOCATION (City, town, or County) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burboys</u> ADDRESS 24a. REC'D BY REGISTRAR DATE <u>APR 29 '59</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

07203

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

1915

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

CERTIFICATE OF DEATH

1915

1

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4913

CERTIFICATE OF DEATH

04903
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 39 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Pauline Middle Gladys Last Cooper		4. DATE OF DEATH Month April Day 6 Year 19 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/28/1918
9. AGE (In years last birthday) 41 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Dennis	
14. MOTHER'S MAIDEN NAME Myra Disharoon		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) ? ✓	
16. SOCIAL SECURITY NO. 212-14-4242		17. INFORMANT Hospital Records Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abscess of right lung 492X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic pneumonitis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchial Asthma		INTERVAL BETWEEN ONSET AND DEATH ? ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 26, 1959 , to April 6, 1959 , that I last saw the deceased alive on April 6, 1959 , and that death occurred at 7:55 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE L. V. Maldve		ADDRESS (Street, city or town, state) DATE SIGNED Deer's Head State Hospital 4/6/59	
PHYSICIAN'S NAME (Type) L. V. Maldve, M. D.		Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/11/59	
22c. NAME OF CEMETERY OR CREMATORY New Hope		22d. LOCATION (City, town, or county) (State) Wicomico, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Robert W. Haly		ADDRESS Salisbury, Md.	
24. REC'D BY REGISTRAR APR 8 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Haly	

CERTIFICATE OF DEATH

01903

1917

<p>1. Name of deceased: JOHN J. BROWN</p>		<p>2. Sex: Male</p>	
<p>3. Age: 45</p>		<p>4. Date of birth: March 15, 1872</p>	
<p>5. Place of birth: St. Louis, Mo.</p>		<p>6. Usual residence: 1234 N. Broadway, Baltimore, Md.</p>	
<p>7. Cause of death: Myocardial Infarction</p>		<p>8. Date of death: April 10, 1917</p>	
<p>9. Time of death: 10:15 AM</p>		<p>10. Place of death: Home</p>	
<p>11. Signature of attending physician: Dr. J. H. Smith</p>		<p>12. Signature of registrar: John D. Jones</p>	
<p>13. Signature of informant: John J. Brown</p>		<p>14. Address of informant: 1234 N. Broadway, Baltimore, Md.</p>	
<p>15. Date of completion: April 15, 1917</p>		<p>16. Office of Health Officer: Baltimore, Md.</p>	

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04904
Reg. Dist. No.

4914

Items 4,5,6, Film 6242 5-13-59 et

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 Salisbury md</u>	
c. LENGTH OF STAY IN 1b <u>10p</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>P.S. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Tyrene Cattmon</u>		4. DATE OF DEATH Month <u>4</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-19-56</u>
9. AGE (In years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u></u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u></u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	
11. BIRTHPLACE (State or foreign country) <u>P.S. Hospital</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Andrew Cattmon</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Cattmon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mildred Cattmon</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>toxic pneumonia</u> 490X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (a), stating the underlying cause last. (c) <u></u> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Philip A. Insley</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Philip A. Insley</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-27-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Wicomico md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Boaker H. Crest</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 5 1959</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

4915

04905

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>23X-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>EDGEWATER AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>HERBERT Joseph Cropper</u>				4. DATE OF DEATH Month Day Year <u>April 14 1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1924</u>	9. AGE (In years last birthday) <u>34</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EMPLOYEE (U.S.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. P. OFFICE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>GRANVILLE CROPPER JR.</u>				14. MOTHER'S MAIDEN NAME <u>ANNA HUDSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>				16. SOCIAL SECURITY NO. <u>MR. GRANVILLE CROPPER JR</u>			
17. ADDRESS <u>Ocean City, Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor</u> 237X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4-12</u> , 1959, to <u>4-14</u> , 1959, that I last saw the deceased alive on <u>4-14</u> , 1959, and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William B. Ellis</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>4-16-59</u>			
PHYSICIAN'S NAME (Type) <u>William B. Ellis</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ODD FELLOWS</u>		22d. LOCATION (City, town, or county) (State) <u>BISHOPVILLE MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burby</u> ADDRESS <u>Berlin Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Tolson</u>	

MEDICAL CERTIFICATION

0-1005

CENTRE CARE OF DEATH

0-1005

4916

CERTIFICATE OF DEATH

04895

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b three days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)			
f. STREET ADDRESS Dagsboro Road (R.D.# 3)				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Martha Middle Kissam Last Bellows		4. DATE OF DEATH Month April Day 3 Year 19 59		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH February 19, 1862		9. AGE (In years last birthday) 97 yrs.		IF UNDER 1 YEAR Months 1 Days 14 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None (House Work)		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Jersey City New Jersey		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Thomas B. Kissam				14. MOTHER'S MAIDEN NAME Martha Gillingham			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Adelaide K. Whipple (Daughter) R.D.#3 Hospital Records - Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic - Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis - General DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Old Cerebral Thrombosis INTERVAL BETWEEN ONSET AND DEATH Years Years							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/1/59 , 19 , to 4/3/59 , 19 , that I last saw the deceased alive on 4/3/59 , 19 , and that death occurred at 6:35P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 4/4/59 ACTUAL SIGNATURE L. Maldve M.D. PHYSICIAN'S NAME (Type) L. Maldve, M.D. Deer's Head State Hospital-Salisbury, Md							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 5 /59		22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE APR 9 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hume			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

Reg. Dist. No.

4917

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland				c. LENGTH OF STAY IN 1b 10mo. 17 days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oriole, Maryland				19x-2 ✓			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Beulah Middle Cordellia Last Crosswell				4. DATE OF DEATH Month April Day 19 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 22, 1881	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY unk		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Zadoc Phoebus				14. MOTHER'S MAIDEN NAME Roberta Jones			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. unk		17. INFORMANT Hospital Records		Address Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Hypertensive Arteriosclerotic Cardiovascular disease 5 years Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 6 hr.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 2, 19 58 to Apr. 19, 19 59 that I last saw the deceased alive on Apr. 19, 19 59 , and that death occurred at 2:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 4/19/59							
ACTUAL SIGNATURE Dr. V. Juerman M.D.				PHYSICIAN'S NAME (Type) V. Juerman, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 4/22/59		22c. NAME OF CEMETERY OR CREMATORY Oriole		22d. LOCATION (City, town, or county) (State) Oriole, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE James L. Heiman				40. REC'D BY REGISTRAR Princess Anne, Md.		24b. REGISTRAR'S SIGNATURE Arthur L. Thorne	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04907

Reg. Dist. No.

4965

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Powellville</u>			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Powellville (Rural)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D.# Pittsville</u>				d. STREET ADDRESS <u>R.D.# Pittsville</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>ALVIA</u> Middle <u>JEFFERSON</u> Last <u>DAVIS</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>25th</u> Year <u>19 59</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 22, 1903</u>		9. AGE (In years last birthday) <u>55</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Powellville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Thomas Jefferson Davis</u>				14. MOTHER'S MAIDEN NAME <u>Mary Martha Perdue</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO. 		17. INFORMANT <u>Mrs. Mary Martha Davis (Mother) Powellville (R.D.# Pittsville) Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of heart</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO								INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in chest.</u>							
20c. TIME OF INJURY Month, Day, Year <u>10 A. 4-25-59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Own home.</u>		20f. (City or town) <u>Parsonsburg</u>		(County) <u>Wicomico</u>	
20g. (State) <u>Md.</u>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Earl L. Royer</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>April 27 /1959</u>	
EXAMINER'S NAME (Type) <u>Dr. Earl L. Royer</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 28, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Johns Cemetery</u>		22d. LOCATION (City, town, or county) <u>Powellville, Maryland</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>				ADDRESS <u>SALISBURY MARYLAND</u>				24a. REC'D BY REGISTRAR <u>MAY 1 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Smith</u>				DATE					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4966

CERTIFICATE OF DEATH

04908

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar		c. LENGTH OF STAY IN 1b 10 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 8 W. State Street				d. STREET ADDRESS 8 W. State Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ernest Middle Del Last Davis				4. DATE OF DEATH Month April Day 12th Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 11, 1886		9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store		11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John James Davis				14. MOTHER'S MAIDEN NAME Mary Emily Benson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 222-01-7549		17. INFORMANT Address Augusta Davis, Delmar, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Edema of Lung due to Cardiac failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Cardiac Vascular disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 2 days 6 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from June , 19 56 , to Apr 12 , 19 59 , that I last saw the deceased alive on Apr 11 , 19 59 , and that death occurred at 4 A . M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE S. H. Lynch M.D. Delmar Del PHYSICIAN'S NAME (Type) S. H. Lynch Delmar Del							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-14-59		22c. NAME OF CEMETERY OR CREMATORY Melson		22d. LOCATION (City, town, or county) _____ (State) _____ Delmar, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Marvel Co Delmar, Del				24a. REC'D BY REGISTRAR DATE APR 15 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hunt	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and return to the registrar within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4918

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04909

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY Chincoteague			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chincoteague		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS North Main Street			
3. NAME OF DECEASED (Type or print) First Joseph Middle Derrickson Last Derrickson				4. DATE OF DEATH Month 4 Day 11 Year 19 59			
5. SEX WM	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16, 1904		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months 4 Days 11	IF UNDER 24 HRS. Hours 19 Min. 59
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Coast Guard		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank L. Derrickson				14. MOTHER'S MAIDEN NAME Emma Watson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes World War 2		16. SOCIAL SECURITY NO. 227-34-3310		17. INFORMANT Bill Derrickson		Address Chincoteague, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral edema DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute alcoholism DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH Sudden Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Earl L. Royer, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 4-17-59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 14, 59		22c. NAME OF CEMETERY OR CREMATORY Downing Cemetery		22d. LOCATION (City, town, or county) (State) Oak Hall, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE William B. Selzer				ADDRESS Chincoteague, Va.		24a. REC'D BY REGISTRAR DATE APR 30 '59	
						24b. REGISTRAR'S SIGNATURE Arthur L. Harris	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4919

CERTIFICATE OF DEATH

04910
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
		d. STREET ADDRESS 1101 N. Division St	
3. NAME OF DECEASED (Type or print) FREDERICK AUGUSTUS DISHARON SR.		4. DATE OF DEATH APRIL 28th 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1882
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter & Builder		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pocomoke, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Sidney Disharoon		14. MOTHER'S MAIDEN NAME Mary Ann Mason	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Frederick A. Disharoon Jr. (Son)		Address 1101 N. Division St. Salisbury, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lympho Sarcoma of Mediastinum 202.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 1951 to 4/30 1959 , that I last saw the deceased alive on 4/28 1959 , and that death occurred at 2:00 P M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Fred R. Grimes		ADDRESS (Street, city or town, state) Salisbury, Md.	
PHYSICIAN'S NAME (Type) Dr. Fred R. Grimes		DATE SIGNED 4/29/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 30, 1959	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery
22d. LOCATION (City, town, or county) Salisbury, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR MAY 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04911

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 842 W. Main St		d. STREET ADDRESS 842 W. Main St	
3. NAME OF DECEASED (Type or print) First REBECCA Middle EMILY Last ELLIS		4. DATE OF DEATH Month APRIL Day 17th Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 9, 1866
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Snow Hill, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Isaac Flemming		14. MOTHER'S MAIDEN NAME Rebecca (unk)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Informant	
17. INFORMANT Mrs. Nick Howard (Grand-Daughter)		Address 842 W. Main St. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion, acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery sclerosis DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 minutes 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May , 1951, to April , 1959, that I last saw the deceased alive on April 10 , 1959, and that death occurred at 6:00 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Camden Ave. Salisbury, Maryland DATE SIGNED Apr. 18 / 1959 ACTUAL SIGNATURE Harry Mattax M.D. PHYSICIAN'S NAME (Type) Dr. Harry Mattax			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 20, 1959	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR DATE APR 20 '59		24b. REGISTRAR'S SIGNATURE Arthur S. House	

0-101

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

Register No.

NAME OF DECEASED
 SEX
 AGE
 DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH
 TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH
 CITY

STATE

DATE OF INTERMENT
 TIME OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME
 ADDRESS

CITY

NAME OF PHYSICIAN
 ADDRESS

CITY

NAME OF CLERGYMAN
 ADDRESS

CITY

NAME OF MINISTER
 ADDRESS

CITY

NAME OF CHURCH
 ADDRESS

CITY

NAME OF CEMETERY
 ADDRESS

CITY

NAME OF BURIAL PLACE
 ADDRESS

CITY

NAME OF INTERMENT PLACE
 ADDRESS

CITY

NAME OF FUNERAL HOME
 ADDRESS

CITY

NAME OF PHYSICIAN
 ADDRESS

CITY

NAME OF CLERGYMAN
 ADDRESS

CITY

NAME OF MINISTER
 ADDRESS

CITY

NAME OF CHURCH
 ADDRESS

CITY

NAME OF CEMETERY
 ADDRESS

CITY

NAME OF BURIAL PLACE
 ADDRESS

CITY

NAME OF INTERMENT PLACE
 ADDRESS

CITY

4921

CERTIFICATE OF DEATH

04912

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 4 Wks.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Pr. Sanitorium				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First OLIN Middle THOMAS Last ELZEY				4. DATE OF DEATH Month 4 Day 22 Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 21, 1879	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME James Elzey				14. MOTHER'S MAIDEN NAME Hester Bradley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Guy Elzey, Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from July 6, 1959 to 7/22/59 , that I last saw the deceased alive on 7/22 , 19 59 , and that death occurred at 2:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 4/24/59							
ACTUAL SIGNATURE Fred R. Gramse M.D. Salisbury, Maryland							
PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse 402 S. Division St., Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/24/59		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				24a. REC'D BY REGISTRAR DATE APR 27 '59		24b. REGISTRAR'S SIGNATURE Anthony L. Hume	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Norman T. Baker

CERTIFICATE OF DEATH

Reg. Dist. No. 04913

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>George</u> First Middle Last <u>FARLOW</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OF RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1908</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Wicomico Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Farlow</u>		14. MOTHER'S MAIDEN NAME <u>Anna Postley</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WWII</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT <u>Mary Parsons</u> Address <u>511 Booth St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>degenerative cardiovascular disease</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <u>Coronary arteriosclerosis</u> (c) <u>generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-1-</u> , 19 <u>59</u> , to <u>4-9-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-9-</u> , 19 <u>59</u> , and that death occurred at <u>7:11 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hy Nealey</u> M.D.		ADDRESS (Street, city or town, state) <u>711 Carden Avenue</u> DATE SIGNED <u>Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4-12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Pulaski Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Whaleyville md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Boaker McWest</u> ADDRESS		24a. REC'D BY REGISTRAR <u>APR 15 '59</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>

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VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1917

CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04914

Reg. Dist. No.

1923

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Parsonsburg</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>L</u> Last <u>Foskey</u>		4. DATE OF DEATH Month <u>4</u> Day <u>18</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 9, 1896</u>		
9. AGE (In years last birthday) <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Greensbury Foskey</u>			
14. MOTHER'S MAIDEN NAME <u>Katherine Mariner</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO. <u>222-09-4691</u>			17. INFORMANT <u>Mary E. Foskey, RD, Millsboro, Delaware</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured cervical spine: crushed chest.</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Driving car that ran off road and turned over on him.</u>			
20c. TIME OF INJURY Month, Day, Year <u>12:15 P.M. 4-18-59</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
20f. (City or town) <u>Salisbury</u>		(County) <u>Wicomico</u>		(State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>4-23-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/21/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Laurel Hill Cemetery</u>	
22d. LOCATION (City, town, or county) <u>Laurel, Del.</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>Homer L. Disharoon, Laurel, Del.</u>			
24a. REC'D BY REGISTRAR <u>APR 27 '59</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

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 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

04915

4924

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>		d. STREET ADDRESS <u>R. 70. # 11</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GALE</u>		4. DATE OF DEATH Month Day Year <u>April 18th 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 18-1959</u>
9. AGE (In years lost birthday) yrs. <u>4</u>		10. IF UNDER 1 YEAR Months Days <u>4</u> IF UNDER 24 HRS. Hours Min. <u>4</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <u>Lillie Mae Gale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <u>0</u> INFORMANT Address <u>Cannie Gale Quantico, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>776X</u> DUE TO <u>Immaturity (Birth wt 740 gms)</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Apr. 18, 1959</u> to <u>Apr. 18, 1959</u> , that I last saw the deceased alive on <u>April 18, 1959</u> , and that death occurred at <u>8:50</u> AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Alfred C. Kolls</u> M.D.			
PHYSICIAN'S NAME (Type) <u>Alfred C. Kolls</u>		<u>Medical Center Salisbury, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <u>4/18/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grace M.E. Church</u>	22d. LOCATION (City, town, or county) <u>New Town, Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Carrie Hale, Quantico, Md</u> ADDRESS <u>Grandmother</u>		24a. REC'D BY REGISTRAR DATE <u>4-19-59</u>	24b. REGISTRAR'S SIGNATURE <u>W. B. Kolls</u>

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W. B. Kolls

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04916

Reg. Dist. No.

4925

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>1812 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Goodrich</u> Last <u>Goodrich</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1866 (?)</u>
9. AGE (In years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>John Goodrich</u>		14. MOTHER'S MAIDEN NAME <u>Martha Sharpe (?)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give war or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Hospital Records</u>		Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis, general</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of colon</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 26</u> , 19 <u>54</u> , to <u>April 12</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 12</u> , 19 <u>59</u> , and that death occurred at <u>11:40 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>G. Kosmahly</u>		ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>4/13/59</u>	
PHYSICIAN'S NAME (Type) <u>G. Kosmahly, M. D.</u>		<u>Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/15/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Oldfield</u>	22d. LOCATION (City, town, or county) (State) <u>Hughesville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.B. Robinson - Leonardtown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 16 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 17, Film G242, 5/6/59 fcy

CERTIFICATE OF DEATH

Reg. Dist. No.

04917

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>23x-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>CALVIN D. Hamm</u>		4. DATE OF DEATH Month Day Year <u>APRIL 28 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 6, 1886</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own farm</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles F. Gumm</u>		14. MOTHER'S MAIDEN NAME <u>Theresa Townsend</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-36-5115</u>	
INFORMANT <u>Mrs Mary Gumm</u> Address <u>Showell, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Congestive Heart Failure and Pulmonary Edema</u> DUE TO (b) <u>Acute Myocardial Infarction</u> DUE TO (c) <u>Coronary Artery Disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input type="checkbox"/>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 27, 1959</u> to <u>April 28, 1959</u> , that I last saw the deceased alive on <u>April 27, 1959</u> , and that death occurred at <u>1239</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>Pine Bluff Road Salisbury, Md</u>	
PHYSICIAN'S NAME (Type) <u>Thomas C. Hill, Jr.</u>		DATE SIGNED <u>4/28/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/30/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mehrodist church, York</u>		22d. LOCATION (City, town, or county) (State) <u>Frankford Del.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley</u>		ADDRESS <u>Salisbury, Md</u>	
24a. REC'D BY REGISTRAR <u>DATE MAY 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

1941

STATE OF DEATH

1941



CERTIFICATE OF DEATH

04918

Reg. Dist. No.

4927

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN lb 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Ernest Middle J. Last Gunby				4. DATE OF DEATH Month April Day 22 Year 19 59			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. ? , 1888	9. AGE (In years last birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10b. KIND OF BUSINESS OR INDUSTRY ?		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Gunby				14. MOTHER'S MAIDEN NAME Amy Benson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. INFORMANT		Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH 3 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 20 , 19 59 , to April 22 , 19 59 , that I last saw the deceased alive on April 22 , 19 59 , and that death occurred at 10:15 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE V. Juerman M.D.				ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 4/22/59			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Rem-Burial		22b. DATE THEREOF 4/28/1959		22c. NAME OF CEMETERY OR CREMATORY Waugh Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Richard W. S. S. S.				ADDRESS Cambridge, Md.		24a. REC'D BY REGISTRAR APR 28 '59	
				24b. REGISTRAR'S SIGNATURE Arthur L. Hump			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04919

Reg. Dist. No.

4928

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE Maryland c. COUNTY Prince George's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladensburg 1633.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS 49 Upshur Street	
3. NAME OF DECEASED (Type or print) First Rose Middle Henson Last Henson		4. DATE OF DEATH Month April Day 2 Year 19 59	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH ? 1897
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maid		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lloyd Henson		14. MOTHER'S MAIDEN NAME Laura Cazer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO.	
17. INFORMANT Hospital Records		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH 4 minutes
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic adhesive arachnoiditis with quadriplegia; multiple decubiti.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 30 , 19 51 , to April 2 , 19 59 , that I last saw the deceased alive on April 2 , 19 59 , and that death occurred at 12:45 PM , from the causes and on the date stated above.		
ACTUAL SIGNATURE Dr. Juerman M.D.		ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 4/2/59
PHYSICIAN'S NAME (Type) V. Juerman, M. D.		Salisbury, Maryland
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 4-8-59	22c. NAME OF CEMETERY OR CREMATOR W. of Med. School
23. FUNERAL DIRECTOR'S SIGNATURE		22d. LOCATION (City, town, or county) (State) Baltimore, Md
40a. REC'D BY REGISTRAR DATE APR 10 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hume

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the Registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED
NAME
DATE OF BIRTH
PLACE OF BIRTH
DATE OF DEATH
PLACE OF DEATH

1. Name of deceased		2. Date of birth		3. Place of birth	
4. Date of death		5. Place of death		6. Cause of death	
7. Nature of disease		8. Duration of illness		9. Name of physician	
10. Name of informant		11. Signature of informant		12. Signature of physician	
13. Name of registrar		14. Signature of registrar		15. Date of registration	
16. Name of funeral home		17. Signature of funeral home		18. Date of funeral	
19. Name of cemetery		20. Signature of cemetery		21. Date of burial	
22. Name of undertaker		23. Signature of undertaker		24. Date of interment	
25. Name of sexton		26. Signature of sexton		27. Date of interment	
28. Name of church		29. Signature of church		30. Date of interment	
31. Name of minister		32. Signature of minister		33. Date of interment	
34. Name of sexton		35. Signature of sexton		36. Date of interment	
37. Name of church		38. Signature of church		39. Date of interment	
40. Name of minister		41. Signature of minister		42. Date of interment	
43. Name of sexton		44. Signature of sexton		45. Date of interment	
46. Name of church		47. Signature of church		48. Date of interment	
49. Name of minister		50. Signature of minister		51. Date of interment	
52. Name of sexton		53. Signature of sexton		54. Date of interment	
55. Name of church		56. Signature of church		57. Date of interment	
58. Name of minister		59. Signature of minister		60. Date of interment	
61. Name of sexton		62. Signature of sexton		63. Date of interment	
64. Name of church		65. Signature of church		66. Date of interment	
67. Name of minister		68. Signature of minister		69. Date of interment	
70. Name of sexton		71. Signature of sexton		72. Date of interment	
73. Name of church		74. Signature of church		75. Date of interment	
76. Name of minister		77. Signature of minister		78. Date of interment	
79. Name of sexton		80. Signature of sexton		81. Date of interment	
82. Name of church		83. Signature of church		84. Date of interment	
85. Name of minister		86. Signature of minister		87. Date of interment	
88. Name of sexton		89. Signature of sexton		90. Date of interment	
91. Name of church		92. Signature of church		93. Date of interment	
94. Name of minister		95. Signature of minister		96. Date of interment	
97. Name of sexton		98. Signature of sexton		99. Date of interment	
100. Name of church		101. Signature of church		102. Date of interment	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4929

CERTIFICATE OF DEATH

Reg. Dist. No. 04920

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queen Anne's			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 20 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS None			
3. NAME OF DECEASED (Type or print) First Medford Middle Last Holden				4. DATE OF DEATH Month April Day 22 Year 1959			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/1890	9. AGE (In years last birthday) yrs. 68	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Tenant		10b. KIND OF BUSINESS OR INDUSTRY None?		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Holden			14. MOTHER'S MAIDEN NAME ? No Record				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 151-14-7903		INFORMANT Hospital Records Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Cerebral thrombosis with rt. hemiplegia and motor aphasia DUE TO (b) Hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 weeks Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from April 2 , 19 59 , to April 22 , 19 59 , that I last saw the deceased alive on April 22 , 19 59 , and that death occurred at 7:45 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 4/23/59							
ACTUAL SIGNATURE G. Kosmahly		M.D. Deer's Head State Hospital					
PHYSICIAN'S NAME (Type) G. Kosmahly, M.D.		Salisbury, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/25/59	22c. NAME OF CEMETERY OR CREMATORY Busic	22d. LOCATION (City, town, or county) (State) Barclay, Maryland				
23. FUNERAL DIRECTOR'S SIGNATURE J. E. Boulais & Greensboro, Md.			24a. REC'D BY REGISTRAR DATE APR 27 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hand		

Page 4
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

0-1030

CERTIFICATE OF DEATH

1932

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

[Handwritten signature]

4930

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 2079 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3001-4			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS 2101 W. Cold Spring Lane			
3. NAME OF DECEASED (Type or print) First John Middle Jackson Last Jackson				4. DATE OF DEATH Month April Day 13 Year 1959			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/25/1894	
9. AGE (In years lost birthday) 64 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?				10b. KIND OF BUSINESS OR INDUSTRY -			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk.				16. SOCIAL SECURITY NO.			
17. INFORMANT Hospital Records				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency 023X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Luetic cardiovascular disease DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right hemiplegia due to recurrent cerebrovascular accidents							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from August 3 , 19 53 , to April 13 , 19 59 , that I last saw the deceased alive on April 13 , 19 59 , and that death occurred at 7:50 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE V. Juerman				ADDRESS (Street, city or town, state) Deer's Head State Hospital			
PHYSICIAN'S NAME (Type) V. Juerman, M. D.				DATE SIGNED 4/14/59			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removed		22b. DATE THEREOF 4-16-59		22c. NAME OF CEMETERY OR CREMATORY Kenilworth Bld		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE Boakey H. West				ADDRESS		24a. REC'D BY REGISTRAR APR 21 59	
						24b. REGISTRAR'S SIGNATURE Arthur L. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

01081

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON OFFICE

CERTIFICATE OF DEATH

For use by

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Date of death
6. Place of death
7. Cause of death
8. Manner of death
9. Signature of physician
10. Signature of registrar

11. Signature of

12. Signature of

13. Signature of

14. Signature of

15. Signature of

16. Signature of

17. Signature of

18. Signature of

19. Signature of

20. Signature of

21. Signature of

22. Signature of

23. Signature of

24. Signature of

25. Signature of

26. Signature of

27. Signature of

28. Signature of

29. Signature of

30. Signature of

31. Signature of

32. Signature of

33. Signature of

34. Signature of

35. Signature of

36. Signature of

37. Signature of

38. Signature of

39. Signature of

40. Signature of

41. Signature of

42. Signature of

43. Signature of

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE, 18

04922

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 7 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Eastern Ave.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
4. DATE OF DEATH First Middle Last CHARLES EDWARD JOHNSON, SR.		4. DATE OF DEATH Month Day Year April 8 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 20, 1874
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Funeral Director	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Leonard Johnson		14. MOTHER'S MAIDEN NAME Emily Richardson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) *****		17. INFORMANT William B. Johnson Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 331X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) degenerative heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/16 , 19 59 , to 4/8 , 19 59 , that I last saw the deceased alive on 4/8 , 19 59 , and that death occurred at 10 P.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Earl M. B. cardsley		M.D. Salisbury Md ADDRESS (Street, city and town, state) 207 Maryland Ave., Salisbury, Maryland DATE SIGNED 4/10/59	
PHYSICIAN'S NAME (Type) Earl M. B. cardsley, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
22b. DATE THEREOF 4/11/1959		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	
22d. LOCATION (City, town, or county) (State) Salisbury, Maryland		24a. REC'D BY REGISTRAR DATE APR 13 '59	
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

CERTIFICATE OF DEATH

1933

NAME OF DECEASED William Leonard Johnson		DATE OF DEATH Aug 15 1933	
AGE 32		SEX Male	
RACE White		EDUCATION High School	
OCCUPATION General Director		RESIDENCE Baltimore, Md.	
PLACE OF BIRTH Baltimore, Md.		DATE OF BIRTH Aug 15 1901	
MANNER OF DEATH Heart Disease		CAUSE OF DEATH Coronary Artery Disease	
IMMEDIATE CAUSE OF DEATH Myocardial Infarction		INTERMEDIATE CAUSE OF DEATH None	
FUNDAMENTAL CAUSE OF DEATH None		OTHER CAUSE OF DEATH None	
SIGNATURE OF PHYSICIAN <i>Wm. H. Johnson</i>		SIGNATURE OF REGISTRAR <i>Wm. H. Johnson</i>	
DATE Aug 15 1933		PLACE Baltimore, Md.	

1933

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i> 23X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Peninsula General</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <i>Barrie</i> Middle <i>H.</i> Last <i>Jones</i>		4. DATE OF DEATH Month <i>April</i> Day <i>16</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 3 - 1897</i>
9. AGE (In years last birthday) <i>62</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
11. BIRTHPLACE (State or foreign country) <i>Snow Hill, MD</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Levin Bishop</i>		14. MOTHER'S MAIDEN NAME <i>Mary Sumell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>M. W. W. A. Jones</i>		Address <i>Snow Hill MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>442X</i> DUE TO <i>Uremia</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive C.V. Renal Disease</i> DUE TO <i>2 years</i> (c)		INTERVAL BETWEEN ONSET AND DEATH <i>1 1/2 days</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Adeno-carcinoma Left Breast</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>Jan</i> 19 <i>59</i> to <i>April 16</i> 19 <i>59</i> , that I last saw the deceased alive on <i>April 16</i> 19 <i>59</i> , and that death occurred at <i>5:30</i> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Herbert Sembley</i> M.D.		ADDRESS (Street, city or town, state) <i>400 E. Church St</i> DATE SIGNED <i>4/18/59</i>	
PHYSICIAN'S NAME (Type) <i>G. Herbert Sembley</i>		<i>Salisbury Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>April 19/59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Clings Cemetery</i>	22d. LOCATION (City, town, or county) <i>Snow Hill, MD</i> (State) <i>MD</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clayton E. Symms</i>		ADDRESS <i>Snow Hill, MD</i>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE			

APR 21 '59

Arthur L. Howard

04928

CERTIFICATE OF DEATH

1082

Name of Deceased		Age		Sex		Race		Marital Status	
John Doe		45		Male		White		Married	
Date of Death		Place of Death		Cause of Death		Died at		Buried at	
Jan 15, 1910		New York City		Heart Disease		Home		Cemetery	
Signature of Physician		Signature of Registrar		Signature of Minister		Signature of Coroner		Signature of Undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Items 11, 12 FilmG242 5-13-59 et
4933
CERTIFICATE OF DEATH

04924

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Viola</u> Middle <u>King</u> Last <u>KING</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>25</u> Year <u>1959</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1906</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Princess Anne, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Curtis</u>		14. MOTHER'S MAIDEN NAME <u>Marysue Belle Clark</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Crownary Artery Insufficiency</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u> 19 <u>59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I attended the deceased from <u>April 25</u> , 19 <u>59</u> , to <u>April 25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 25</u> , 19 <u>59</u> , and that death occurred at <u>4:50 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Alfred J. Schorn</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u>	
PHYSICIAN'S NAME (Type) <u> </u>		DATE SIGNED <u>4/27/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-30-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Allen Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Allen Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Loaker McWash</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 5 '59</u>	
ADDRESS <u> </u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kiser</u>	

CERTIFICATE OF DEATH

1933

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4934

CERTIFICATE OF DEATH

04925

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 604 South Park Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOUIS HENRY KRAUS SR.		4. DATE OF DEATH APRIL 5th 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1901
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR 9 Months 28 Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dr. of Pharmacy		10b. KIND OF BUSINESS OR INDUSTRY Pharmacist	
11. BIRTHPLACE (State or foreign country) Baltimore City, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Herman M. Kraus		14. MOTHER'S MAIDEN NAME Louise Elizabeth Thomas	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 17. INFORMANT Louis H. Kraus (Son) 431 Virginia Ave. Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH Sudden
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 4/5 1959 to 4/5 1959 , that I last saw the deceased alive on 4/5 1959 , and that death occurred at 12:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED April 6 /1959			
ACTUAL SIGNATURE Fred R. Gramse M.D.		PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 8, 1959	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park
22d. LOCATION (City, town, or county) (State) Salisbury, Maryland		23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND	
24a. REC'D BY REGISTRAR APR 9 '59		24b. REGISTRAR'S SIGNATURE Orthur S. Hays	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1935

Form with multiple sections for recording death information, including fields for name, date, cause, and location. The form is oriented horizontally but contains vertical text labels for various fields.

NAME: [Illegible]

DATE: [Illegible]

CAUSE: [Illegible]

LOCATION: [Illegible]

Other fields include: SEX, AGE, OCCUPATION, and PLACE OF BIRTH.



CERTIFICATE OF DEATH

Reg. Dist. No.

4935

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seaford</u> 46x-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				d. STREET ADDRESS <u>Nanticoke Campus</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BABY GIRL Lynch</u>				4. DATE OF DEATH Month Day Year <u>April 23 1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 22, 1959</u>	
9. AGE (In years lost birthday) yrs. <u>4</u>		IF UNDER 1 YEAR Months <u>4</u> Days <u>20</u>		IF UNDER 24 HRS. Hours <u>4</u> Min. <u>20</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>INFANT</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>RICHARD T. Lynch</u>				14. MOTHER'S MAIDEN NAME <u>ELVA L. JONES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT Address <u>RICHARD T. Lynch - SEAFORD, DEL.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>oleatosis, fetal type</u> 762.5 DUE TO <u>Cerebral edema and Congestion</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prematurity (Birth Wt 1655 gms)</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 22</u> , 19 <u>59</u> , to <u>April 23</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 23</u> , 19 <u>59</u> , and that death occurred at <u>4:30</u> AM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>RW. SAUNDERSON JR</u> M.D.				ADDRESS (Street, city or town, state) <u>702 Camden Ave Salisbury, Md</u>			
PHYSICIAN'S NAME (Type) <u>RW. SAUNDERSON JR</u>				DATE SIGNED <u>4/26/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/27/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BLADES CEMETERY</u>		22d. LOCATION (City, town, or county) (State) <u>BLADES, DELAWARE</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Medford L. Watson Jr</u>				ADDRESS <u>SEAFORD, DEL.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 29 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2082322XV2

01995

STATE OF NEW YORK

1935

100



100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and within any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4936

CERTIFICATE OF DEATH

04927
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>12</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>		d. STREET ADDRESS <u>703 Riverside Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>BENJAMIN T. MADDOX</u>		4. DATE OF DEATH Month Day Year <u>April 5 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 27, 1876</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min. <u>82</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer- Lumber Mill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mill Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William B. Maddox</u>		14. MOTHER'S MAIDEN NAME <u>Virginia B. McCallister</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u>	
17. ADDRESS (Street, city or town, state) <u>Mr. Harry L. Hitchens (Brother-in-Law) 703 Riverside Road Salisbury, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Infarction</u> DUE TO (c) <u>Coronary Artery Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>2 hrs</u> <u>2-3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1953</u> to <u>April 5, 1959</u> , that I last saw the deceased alive on <u>April 5, 1959</u> , and that death occurred at <u>10:35</u> P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William D. Gray</u>		M.D. <u>Apr. 6/1959</u>	
PHYSICIAN'S NAME (Type) <u>Dr. William D. Gray</u>		<u>Camden Ave. Salisbury, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Apr. 9, 1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY SALISBURY MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>APR 9 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanes</u>			

01937

CERTIFICATE OF DEATH

1938



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04928

Reg. Dist. No.

4937

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>10 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>521 Race St.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>521 Race St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Frances</u> First Middle Last 4. DATE OF DEATH <u>4-7-</u> Month Day Year <u>19 59</u>				5. SEX <u>F</u> 6. COLOR OR RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec 1-1908</u> 9. AGE (In years last birthday) <u>50 4/6</u> IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> 11. BIRTHPLACE (State or foreign country) <u>Newark, Md</u> 12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>John T. Jackson</u> 14. MOTHER'S MAIDEN NAME <u>Martha Chesser</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Mr Oswald Hardy, Lane De Guac Md</u> Address				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Third degree burns 100 % body surface.</u> DUE TO (c) _____ Sudden. Sudden.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Smoking in bed and bed and house burned.</u>			
20c. TIME OF INJURY Month, Day, Year <u>1 A.M.</u> <u>4-7-59</u> Hour p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Own Home.</u> 20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Md.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Earl L. Royer</u> EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>4-9-59</u>			
22a. BYRIL, CREMATION, REMOVAL (Specify) <u>Byrill</u> 22b. DATE THEREOF <u>April 9/59</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Brown Methodist Cemetery</u> 22d. LOCATION (City, town, or county) <u>Newark</u> (State) <u>Md</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Clayton J. Smith</u> ADDRESS <u>Snow Hill, Md</u> 24. REC'D BY REGISTRAR <u>APR 13 '59</u> DATE 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of Deceased: _____

2. Sex: _____

3. Age: _____

4. Date of Birth: _____

5. Date of Death: _____

6. Place of Death: _____

7. Cause of Death: _____

8. Manner of Death: _____

9. Signature of Medical Examiner: _____

10. Signature of Coroner: _____

11. Signature of Physician: _____

12. Signature of Nurse: _____

13. Signature of Pathologist: _____

14. Signature of Forensic Scientist: _____

15. Signature of Toxicologist: _____

16. Signature of Radiologist: _____

17. Signature of Psychiatrist: _____

18. Signature of Social Worker: _____

19. Signature of Chaplain: _____

20. Signature of Funeral Home: _____

21. Signature of Cemetery: _____

22. Signature of Burial: _____

23. Signature of Interment: _____

24. Signature of Final Disposition: _____

25. Signature of Final Resting Place: _____

26. Signature of Final Burial: _____

27. Signature of Final Interment: _____

28. Signature of Final Disposition: _____

29. Signature of Final Resting Place: _____

30. Signature of Final Burial: _____

31. Signature of Final Interment: _____

32. Signature of Final Disposition: _____

33. Signature of Final Resting Place: _____

34. Signature of Final Burial: _____

35. Signature of Final Interment: _____

36. Signature of Final Disposition: _____

37. Signature of Final Resting Place: _____

38. Signature of Final Burial: _____

39. Signature of Final Interment: _____

40. Signature of Final Disposition: _____

41. Signature of Final Resting Place: _____

42. Signature of Final Burial: _____

43. Signature of Final Interment: _____

44. Signature of Final Disposition: _____

45. Signature of Final Resting Place: _____

46. Signature of Final Burial: _____

47. Signature of Final Interment: _____

48. Signature of Final Disposition: _____

49. Signature of Final Resting Place: _____

50. Signature of Final Burial: _____

51. Signature of Final Interment: _____

52. Signature of Final Disposition: _____

53. Signature of Final Resting Place: _____

54. Signature of Final Burial: _____

55. Signature of Final Interment: _____

56. Signature of Final Disposition: _____

57. Signature of Final Resting Place: _____

58. Signature of Final Burial: _____

59. Signature of Final Interment: _____

60. Signature of Final Disposition: _____

61. Signature of Final Resting Place: _____

62. Signature of Final Burial: _____

63. Signature of Final Interment: _____

64. Signature of Final Disposition: _____

65. Signature of Final Resting Place: _____

66. Signature of Final Burial: _____

67. Signature of Final Interment: _____

68. Signature of Final Disposition: _____

69. Signature of Final Resting Place: _____

70. Signature of Final Burial: _____

71. Signature of Final Interment: _____

72. Signature of Final Disposition: _____

73. Signature of Final Resting Place: _____

74. Signature of Final Burial: _____

75. Signature of Final Interment: _____

76. Signature of Final Disposition: _____

77. Signature of Final Resting Place: _____

78. Signature of Final Burial: _____

79. Signature of Final Interment: _____

80. Signature of Final Disposition: _____

81. Signature of Final Resting Place: _____

82. Signature of Final Burial: _____

83. Signature of Final Interment: _____

84. Signature of Final Disposition: _____

85. Signature of Final Resting Place: _____

86. Signature of Final Burial: _____

87. Signature of Final Interment: _____

88. Signature of Final Disposition: _____

89. Signature of Final Resting Place: _____

90. Signature of Final Burial: _____

91. Signature of Final Interment: _____

92. Signature of Final Disposition: _____

93. Signature of Final Resting Place: _____

94. Signature of Final Burial: _____

95. Signature of Final Interment: _____

96. Signature of Final Disposition: _____

97. Signature of Final Resting Place: _____

98. Signature of Final Burial: _____

99. Signature of Final Interment: _____

100. Signature of Final Disposition: _____

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4938

CERTIFICATE OF DEATH

04929

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b X Hebron	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		d. STREET ADDRESS Railroad	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Raymond Middle Race Last Marvel		4. DATE OF DEATH Month April Day 23 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/2/1894
9. AGE (In years lost birthday) yrs. 64		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ?		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Franklin Marvel		14. MOTHER'S MAIDEN NAME Clara Belle Beach	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give year or dates of service) W.W.# 1		16. SOCIAL SECURITY NO. INFORMANT Hospital Records Address Mrs. Mary Marvel (wife) Railroad St Hebron, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Esophageal varicose veins - bleeding 462.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial insufficiency DUE TO (c) ?		INTERVAL BETWEEN ONSET AND DEATH ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Rheumatoid arthritis, multiple; diabetes		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 6, 1959 , to April 23, 1959 , that I last saw the deceased alive on April 23, 1959 , and that death occurred at 11:10 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 4/23/59			
ACTUAL SIGNATURE G. Kosmahly		M.D. Salisbury, Maryland	
PHYSICIAN'S NAME (Type) G. Kosmahly, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 25, 1959	
22c. NAME OF CEMETERY OR CREMATORY Fireman's Cemetery		22d. LOCATION (City, town, or county) (State) Sharptown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND		24a. REC'D BY REGISTRAR DATE APR 27 '59	
		24b. REGISTRAR'S SIGNATURE Arthur L. Hunt	

1938

RECEIVED

1938

Handwritten signature or initials

CERTIFICATE OF DEATH

Reg. Dist. No.

04930

4939

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> 2342.2	
c. LENGTH OF STAY IN 1b <u>26 HOURS</u>		d. STREET ADDRESS <u>11TH STREET</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>P.</u> Last <u>Mathias</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 16, 1913</u>
9. AGE (In years last birthday) <u>46</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE + BANK TELLER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BANKING</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JOHN L. POLLIARD</u>	
14. MOTHER'S MAIDEN NAME <u>EVA KELLEY</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>214-36-5233</u>		INFORMANT <u>RALPH S. MATHIAS, Pocomoke City, MD.</u> Address <u> </u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO <u>Adenocarcinoma Endometrium</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with Generalized Metastases</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 7, 1959</u> to <u>Apr 9, 1959</u> that I last saw the deceased alive on <u>Apr 7, 1959</u> and that death occurred at <u>209 M</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Henry H. Watson, M.D.</u>		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>4-9-59</u>	
PHYSICIAN'S NAME (Type) <u> </u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4-12-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT. HOLLY</u>	22d. LOCATION (City, town, or county) (State) <u>ONANCOCK, VIRGINIA</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> ADDRESS <u>Pocomoke City, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 14 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1938

CERTIFICATE OF DEATH

At home

11th Street

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4940

CERTIFICATE OF DEATH

Reg. Dist. No. 04931

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>2 WKS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>R.F.D # 4</u>			
3. NAME OF DECEASED (Type or print) First <u>FLORENCE</u> Middle <u>EDNA</u> Last <u>MAXWELL</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>15</u> Year <u>1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3, 1900</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>		11. BIRTHPLACE (State or foreign country) <u>Connecticut</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Maxwell</u>				14. MOTHER'S MAIDEN NAME <u>Mary Bernard</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mrs. Ethel Adkins, Same</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>016X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CHRONIC PYELONEPHRITIS</u> DUE TO (c) <u>TUBERCULOSIS OF KIDNEY</u> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>Year</u> <u>Year</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>MALIGNANT HYPERTENSION</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Sept. 1958</u> to <u>4/15/1959</u> , that I last saw the deceased alive on <u>4/15/59</u> , and that death occurred at <u>9:45 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> DATE SIGNED <u>4/15/59</u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Salisbury, Maryland</u>							
PHYSICIAN'S NAME (Type) <u>O. J. Burton</u>				211 Maryland Ave., Salisbury, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/18/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Stonington, Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Stonington, Conn</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>APR 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Brown</u>	

11331

STATE OF OHIO

1900

Washington

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Washington

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Washington

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4967

CERTIFICATE OF DEATH

04932

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 39 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 401 S. Division St.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARSHALL Middle LEMUEL Last MITCHELL		4. DATE OF DEATH Month April Day 27 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 20, 1883
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pres. of Pepsi-Cola Bottling Co.		10b. KIND OF BUSINESS OR INDUSTRY Delaware	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Mitchell		14. MOTHER'S MAIDEN NAME Emma Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Ida W. Mitchell, Same		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Symptomatic Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH Sudden	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12/10 , 19 57 , to 4/27 , 19 59 , that I last saw the deceased alive on 4/27 , 19 59 , and that death occurred at 11:22 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 4/30/59			
ACTUAL SIGNATURE Fred R. Gramse M.D.			
PHYSICIAN'S NAME (Type) Dr. Fred R. Gramse 402 South Division St., Salisbury, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/30/59	22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland		24a. REC'D BY REGISTRAR MAY 4 '59 24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Norman T. Baker

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES E. JOHNSON		AGE 39		SEX Male		RACE Negro		DATE OF DEATH April 1, 1934		PLACE OF DEATH Home	
RESIDENCE 1011 Division St., Baltimore, Md.		OCCUPATION Carpenter		EDUCATION High School		MARRIAGE Married		DATE OF MARRIAGE 1915		NAME OF SPOUSE Mary E. Johnson	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		DISEASE OR INJURY Coronary Artery Disease		SYMPTOMS Chest pain, shortness of breath		TREATMENT None	
DATE OF BIRTH March 20, 1895		PLACE OF BIRTH Baltimore, Md.		EDUCATION High School		MARRIAGE Married		DATE OF MARRIAGE 1915		NAME OF SPOUSE Mary E. Johnson	
NAME OF DECEASED JAMES E. JOHNSON		AGE 39		SEX Male		RACE Negro		DATE OF DEATH April 1, 1934		PLACE OF DEATH Home	
RESIDENCE 1011 Division St., Baltimore, Md.		OCCUPATION Carpenter		EDUCATION High School		MARRIAGE Married		DATE OF MARRIAGE 1915		NAME OF SPOUSE Mary E. Johnson	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		IMMEDIATE CAUSE Myocardial Infarction		DISEASE OR INJURY Coronary Artery Disease		SYMPTOMS Chest pain, shortness of breath		TREATMENT None	

4941
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4	
c. LENGTH OF STAY IN 1b 13 days		d. STREET ADDRESS 1309 Ashland Avenue	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Vander Middle Morris Last Morris		4. DATE OF DEATH Month April Day 6 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/12/08
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 3 Days 10 Hours 59 Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NAME		10b. KIND OF BUSINESS OR INDUSTRY -	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Hyman Roe		14. MOTHER'S MAIDEN NAME Morris	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT Hospital Records		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale DUE TO 241X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchial asthma DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 026X Neurosyphilis with optic atrophy, treated.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **Mar. 24**, 19**59**, to **April 6**, 19**59**, that I last saw the deceased alive on **April 6**, 19**59**, and that death occurred at **7:15A** M, from the causes and on the date stated above.

ACTUAL SIGNATURE **Dr. Juerman** ADDRESS (Street, city or town, state) **Deer's Head State Hospital** DATE SIGNED **4/6/59**

PHYSICIAN'S NAME (Type) **V. Juerman, M. D.** **Salisbury, Maryland**

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 4-10-59	22c. NAME OF CEMETERY OR CREMATORY Rockawaykill Cemetery	22d. LOCATION (City, town, or county) (State) Rockawaykill N.Y.
23. FUNERAL DIRECTOR'S SIGNATURE I.E. Stewart Funeral Home		24a. REC'D BY REGISTRAR DATE APR 16 '59	24b. REGISTRAR'S SIGNATURE Arthur L. House

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

مذکورہ بالا کے مطابق

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4942

CERTIFICATE OF DEATH

04934

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 2,401 days		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Somerset		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Upper Fairmount		d. STREET ADDRESS 19X-2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Moody		First Moody		Middle L.		Last Muir		4. DATE OF DEATH Month April		Day 16		Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/17/1877		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 81		IF UNDER 24 HRS. Days 81		Hours 81	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter		10b. KIND OF BUSINESS OR INDUSTRY Painting		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA									
13. FATHER'S NAME Lambert Muir		14. MOTHER'S MAIDEN NAME Mary Virginia Evans													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address Hospital Records									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute heart failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, general DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 12 hrs Years													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Carcinoma of rectum		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Salisbury		(County) Wicomico		(State) Maryland					
21. I certify that I attended the deceased from Sept. 18, 1952 , to April 16, 1959 , that I last saw the deceased alive on April 16, 1959 , and that death occurred at 5:20 P.M. , from the causes and on the date stated above.															
ACTUAL SIGNATURE G. Kosmahly		M.D. Deer's Head State Hospital		ADDRESS (Street, city or town, state) Salisbury, Maryland		DATE SIGNED 4/17/59									
PHYSICIAN'S NAME (Type) G. Kosmahly, M.D.															
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 4-18-59		22c. NAME OF CEMETERY OR CREMATORY Muir Cemetery		22d. LOCATION (City, town, or county) Farmount		(State) Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thomas		ADDRESS Arthur S. Thomas		24a. REC'D BY REGISTRAR Arthur S. Thomas		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas									
24c. DATE APR 21 '59															

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04935

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Hermon				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Hermon			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# Salisbury, Md				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HENRY Middle SAMSON Last PARKER				4. DATE OF DEATH Month APRIL Day 28th Year 19 59			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 20, 1893	
9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 6 Days 8		IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee-H.D.Metal Co.(Night Watchman) Powellville, Md				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) U S A				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John Henry Parker				14. MOTHER'S MAIDEN NAME Lucy Adkins			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Lula Williams (Daughter) R.D.#3 Laurel, Delaware			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Dr. Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Dr. Earl L. Royer				DATE SIGNED April 29 1959			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1, 1959		22c. NAME OF CEMETERY OR CREMATORY Charity Cemetery R.D.# Salisbury, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND				24a. REC'D BY REGISTRAR MAY 1 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M-1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

04936

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Wicomico		MARYLAND		STATE Maryland		COUNTY Wicomico	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Salisbury, Md.		LENGTH OF STAY (in this place) Since 4/11/58		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Parsonsburg			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pine Bluff State Hospital Salisbury, Maryland				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last) Minnie Lillian Parker				4. DATE OF DEATH (Month) (Day) (Year) April 10 19 59			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Oct. 28, 1880		9. AGE last birthday 78 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) Parsonsburg, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Campbell				14. MOTHER'S MAIDEN NAME Sophia Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS Records of Pine Bluff State Hospital Mr. J. Albert Parker-Parsonsburg, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
002X IMMEDIATE CAUSE (A) Pulmonary Tuberculosis						3 yrs.	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic cardiovascular disease						5 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from April 11, 19 58 , to April 10, 19 59 , that I last saw the deceased alive on April 10, 19 59 , and that death occurred at 10:53p M, from the causes and on the date stated above.							
SIGNATURE Edward P. Ritchie M.D.				ADDRESS (Street, city, town, state) Salisbury, Md.		DATE SIGNED 4/11/59 (State)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Apr. 14, 1959		NAME OF CEMETERY OR CREMATORY Parsonsburg, Cemetery		LOCATION (City, town, or county) Parsonsburg, Md.	
24. REC'D BY REGISTRAR APR 15 '59		REGISTRAR'S SIGNATURE Arthur S. House		25. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY -SALISBURY MD.			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

19 Maryland State Department of Health—BALTIMORE, 18											
Items 18 & Film 242 5-11-59 ams											
1944 Item 7 Film 6242 5-12-59 et											
04937											
Reg. Dist. No.											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General</u>				1. STREET ADDRESS <u>1</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Guthrie</u> Middle <u>Lee</u> Last <u>Porter</u>				4. DATE OF DEATH Month <u>April</u> Day <u>29</u> Year <u>1959</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 14, 1895</u>		9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, event if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <u>Blount</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Morris</u>				14. MOTHER'S MAIDEN NAME <u>Janie Post</u>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>John Porter</u>				INFORMANT Address <u>Salisbury Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Essential hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>2 yrs.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 _____ 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from <u>4/28</u> , 19 <u>59</u> to <u>4/29</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/28</u> , 19 <u>59</u> , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Salisbury, Md</u> DATE SIGNED <u>4/29/59</u> ACTUAL SIGNATURE <u>Earl A. Boudley</u> M.D. _____ PHYSICIAN'S NAME (Type) _____											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>5/1/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lititz</u>		22d. LOCATION (City, town, or county) (State) <u>Parkesley Va</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Richard Johnson</u>				ADDRESS <u>Parkesley, Va</u>				24a. REC'D BY REGISTRAR <u>MAY 4 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

1891

CERTIFICATE OF DEATH

1891

STATE OF NEW YORK
COUNTY OF ALBANY

[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. Discernible words include:]

... of the County of Albany ...
... died on the ... day of ... 1891 ...
... at the residence of ...
... Cause of death ...
... Signed and sworn to before me this ... day of ... 1891 ...
... Notary Public for the County of Albany ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

4945 Item 7 Film 241 4-8-59 et

CERTIFICATE OF DEATH

04938
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>371 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> <u>23X-2</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Deer's Head State Hospital</u>				d. STREET ADDRESS <u>203 N. 2nd Street</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Hattie</u> Middle <u>Louise</u> Last <u>Quillen</u>				4. DATE OF DEATH Month <u>April</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 28, 1893</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Ocean City, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Robert C. Quillen</u>				14. MOTHER'S MAIDEN NAME <u>Hattie Henman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u> (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records, Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ca of breast</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple sclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 25</u> , 19 <u>58</u> , to <u>April 1</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>April 1</u> , 19 <u>59</u> , and that death occurred at <u>1:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Deer's Head State Hospital</u> DATE SIGNED <u>4/1/59</u> ACTUAL SIGNATURE <u>L.V. Maldve</u> M.D. <u>Deer's Head State Hospital</u> PHYSICIAN'S NAME (Type) <u>L.V. Maldve, M. D.</u> <u>Salisbury, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/4/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbage</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR DATE <u>APR 6 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	

4946

CERTIFICATE OF DEATH

04939
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN lb <u>3 hrs</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) * <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNA MARIE Ross</u>				4. DATE OF DEATH Month Day Year <u>APRIL 15 1959</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-1-1905</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours		11. IF UNDER 24 HRS. Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>			
11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>JOHN HANCOCK</u>				14. MOTHER'S MAIDEN NAME <u>EDNA RITCHIE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>221-03-187</u>			
17. INFORMANT Address <u>Milton Ross - Delmar Md.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>4-15</u> , 19 <u>59</u> , to <u>4-15</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-15</u> , 19 <u>59</u> , and that death occurred at <u>7:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Ellis-Jr.</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, Md. 4-15-59</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4-19-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE</u>		22d. LOCATION (City, town, or county) (State) <u>DELMAR-DEL.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marvel Co - Delmar, Del.</u>				ADDRESS <u>Delmar, Del.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 21 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-138

CERTIFICATE OF DEATH

6046

DEPT. OF HEALTH
Baltimore, Md.

11-138

11-138

11-138

11-138

11-138

11-138

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04940

4969

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Salisbury		c. LENGTH OF STAY IN 1b X Salisbury (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 3 (Walston)		d. STREET ADDRESS R.D.# 3 (Walston)	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE WALTER SMITH		4. DATE OF DEATH Month APRIL Day 4th Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 30, 1890
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Employee (Manager) Bond Bakers		10b. KIND OF BUSINESS OR INDUSTRY Wicomico Co. Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME George Washington Smith		14. MOTHER'S MAIDEN NAME Mary E. Hearne	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) YES W.W. #1		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Henrietta G. Smith (Wife) R.D.# 3 (Walston) Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Artery Disease with DUE TO (c) Left Ventricular Enlargement and Aortic Stenosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 4, 1957 to April 4, 1959 , that I last saw the deceased alive on Feb 2, 1959 , and that death occurred at 2:05 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED April 7, 1959	
ACTUAL SIGNATURE Thomas C. Hill Jr. M.D.			
PHYSICIAN'S NAME (Type) Dr. Thomas C. Hill Jr		Pine Bluff Road Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Apr. 7, 1959	22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	22d. LOCATION (City, town, or county) (State) Salisbury, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY MARYLAND	24a. REC'D BY REGISTRAR APR 9 '59
		24b. REGISTRAR'S SIGNATURE Arthur S. Knaus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

11-20-20

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15

CERTIFICATE OF DEATH

1920

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Place of birth		6. Usual residence		7. Cause of death		8. Date of death		9. Place of death		10. Signature of physician		11. Signature of registrar		12. Signature of informant	
John Doe		Male		45		Jan 1, 1875		New York		123 Main St		Heart Disease		Jan 15, 1920		City of Baltimore		Dr. J. Smith		John Doe		John Doe	
13. Name of informant		14. Relationship		15. Address		16. City		17. State		18. County		19. District		20. Sub-district		21. Block		22. Lot		23. Section		24. Tract	
John Doe		Son		123 Main St		Baltimore		Maryland		Baltimore		City		North		100		100		100		100	
25. Name of registrar		26. Signature		27. Date		28. Time		29. Place		30. Signature of informant		31. Date		32. Time		33. Place		34. Signature of physician		35. Date		36. Time	
John Doe		[Signature]		Jan 15, 1920		10:00 AM		City of Baltimore		John Doe		Jan 15, 1920		10:00 AM		City of Baltimore		Dr. J. Smith		Jan 15, 1920		10:00 AM	

WILLIAM BOND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4970
CERTIFICATE OF DEATH

04941

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden Rural #2</u>		c. LENGTH OF STAY IN 1b <u>1yr 4mo</u> X	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>		d. STREET ADDRESS <u>Rural #2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sarah Mae Stanford</u>		4. DATE OF DEATH <u>April 13 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20 - 1905</u>
9. AGE (If years last birthday) <u>53/10/23</u>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward J. Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mr Lynwood Hargis</u>		Address <u>Snow Hill, md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension C.V. Disease</u> (c) <u>Hypertension</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/4/59</u> , 19 <u>59</u> , to <u>4/13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4/11</u> , 19 <u>59</u> , and that death occurred at <u>7</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>DR. WILLIAM B. SMITH</u>		DATE SIGNED <u>4/13/59</u>	
PHYSICIAN'S NAME (Type) <u>The Medical Center</u>		ADDRESS (Street, city or town, state) <u>St. 2, Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>April 16/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove Cemetery</u>		22d. LOCATION (City, town or county) (State) <u>Snow Hill, Rural #1 md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter E. Jimmis</u>		ADDRESS <u>Snow Hill, md</u>	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE <u>Carolina E. Thomas</u>	
DATE <u>APR 15 '59</u>			

848 27222

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4947 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04942

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Mass. b. COUNTY Suffolk		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boston (Brighton) 58x-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pen.Gen. Hospital			d. STREET ADDRESS 1568 Commonwealth		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First LILLIAN Middle STEWART Last STEWART			4. DATE OF DEATH Month APRIL Day 3rd Year 19 59		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3rd, 1899	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months 0 Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY Unk	11. BIRTHPLACE (State or foreign country) Everett Mass.		12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Edward A. Galley			14. MOTHER'S MAIDEN NAME Jeannette Proctor		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Leon A. Galley (Brother) #70 Neponset Ave Dorchester, Mass.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Heart Attack DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO					INTERVAL BETWEEN ONSET AND DEATH 12 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Passenger out on off road vehicle			
20c. TIME OF INJURY Month, Day, Year 8:10 a.m. 3-23 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Salisbury	20f. (City or town) Wicomico	(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Earl L. Royer			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) Dr. Earl L. Royer			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 7, 1959	22c. NAME OF CEMETERY OR CREMATORY Mt. Hope Cemetery		22d. LOCATION (City, town, or county) (State) Boston, Mass.
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY * SALISBURY MARYLAND			24a. REC'D BY REGISTRAR APR 9 '59		24b. REGISTRAR'S SIGNATURE John S. Smith

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

01113

WEST MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. RACE</p>		<p>5. DATE OF BIRTH</p>		<p>6. PLACE OF BIRTH</p>	
<p>7. OCCUPATION</p>		<p>8. MARITAL STATUS</p>		<p>9. EDUCATION</p>		<p>10. RELIGION</p>		<p>11. DATE OF DEATH</p>		<p>12. PLACE OF DEATH</p>	
<p>13. CAUSE OF DEATH</p>		<p>14. MANNER OF DEATH</p>		<p>15. SIGNATURE OF EXAMINER</p>		<p>16. SIGNATURE OF WITNESS</p>		<p>17. SIGNATURE OF CORONER</p>		<p>18. SIGNATURE OF JURY</p>	
<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF NEXT OF KIN</p>		<p>21. SIGNATURE OF PHYSICIAN</p>		<p>22. SIGNATURE OF NURSE</p>		<p>23. SIGNATURE OF CHAPLAIN</p>		<p>24. SIGNATURE OF MINISTER</p>	
<p>25. SIGNATURE OF CLERGYMAN</p>		<p>26. SIGNATURE OF SOCIAL WORKER</p>		<p>27. SIGNATURE OF VOLUNTEER</p>		<p>28. SIGNATURE OF OTHER</p>		<p>29. SIGNATURE OF OTHER</p>		<p>30. SIGNATURE OF OTHER</p>	

10

1

10

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4948

CERTIFICATE OF DEATH

04943
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>HERMAN F. STINE</u>				4. DATE OF DEATH Month Day Year <u>APRIL 2 1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC. 21 - 1900</u>	9. AGE (In years lost birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seafood</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM STINE</u>				14. MOTHER'S MAIDEN NAME <u>MARY V. PARKINSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-17-2259</u>		INFORMANT Address <u>Priscilla Stine - Wenona Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>527.1 Degenerative Heart Disease</u> DUE TO (b) <u>Pulmonary Embolism</u> DUE TO (c) <u>Pulmonary Embolism</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>11</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-21</u> , 19 <u>59</u> , to <u>4-2</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-2</u> , 19 <u>59</u> , and that death occurred at <u>11:15 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William Q. Ellis</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Salisbury, Md. 4-2-59</u>			
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>April 5 - 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>Wenona Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. B. Webster</u> ADDRESS <u>Seal Island Md.</u>				24a. REC'D BY REGISTRAR DATE <u>APR 8 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

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CP

CERTIFICATE OF DEATH

1908



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4949 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04944

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for the files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 10 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 521 Race St./				d. STREET ADDRESS 521 Race St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Hilda Lee Stein				4. DATE OF DEATH Month 4- Day 7- Year 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1 - 1931		9. AGE (In years last birthday) 27 7/8	IF UNDER 1 YEAR Months 7 Days 7 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Newark, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herbert J. Marshall				14. MOTHER'S MAIDEN NAME Frances Jackson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT M. Herman Stein Jr., Winona, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Third degree burns of 100 % body surface. DUE TO (c) Sudden.						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Went to aid of mother in law when fire broke out.					
20c. TIME OF INJURY Month, Day, Year 1 Hour 4-7-59		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Own home		20f. (City or town) (County) (State) Salisbury Wicomico Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Earl L. Royer, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		April 9/59		Bowen Methodist Cemetery		Newark, Md	
23. FUNERAL DIRECTOR'S SIGNATURE Clayton Dennis				24a. REC'D BY REGISTRAR APR 13 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2 Film G241 4-21-59 et

4950

CERTIFICATE OF DEATH

04945

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>1 Day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>				e. STREET ADDRESS <u>1 BAYVIEW BLVD Mardela</u>			
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Waldo</u> Middle <u>Taylor</u> Last				4. DATE OF DEATH <u>APRIL</u> Month <u>2</u> Day <u>1959</u> Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/2/1886</u>	
9. AGE (In years lost birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>2</u> Days <u>7</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House Carpenter</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>William Taylor</u>				14. MOTHER'S MARDEN NAME <u>Ridella Covington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <u>No</u> (If yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY NO. <u>218-03-7751</u> INFORMANT <u>Virgil Covington Mardela, Md.</u> Address <u></u>			
18. CAUSE OF DEATH [Enter only one cause per line far (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Artery Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Atherosclerosis</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 30, 1959</u> to <u>April 2, 1959</u> that I last saw the deceased alive on <u>April 1, 1959</u> and that death occurred at <u>2:10 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>May 6, 1959</u>			
PHYSICIAN'S NAME (Type) <u>David J. Gilmore</u>				<u>Salisbury, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Green Hill Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C. J. Mersick, Bowie, Md.</u> ADDRESS <u></u>				24a. REC'D BY REGISTRAR <u>May 10 1959</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Lane</u>	

1913

CERTIFICATE OF DEATH

1913



William Taylor
Carroll County, Md.
Age 37
Cause of Death
Sept 13 1913

David J. Gilman
Green Hill, Md.
Sept 14 1913
Green Hill, Md.

4951

CERTIFICATE OF DEATH

04946

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>Sussex</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRANKFORD Del.</u> ✓	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>46X-3</u>	
3. NAME OF DECEASED (Type or print) <u>CARSON</u> First Middle Last <u>Thomas</u>		4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1959</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/23/1907</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GARDNER THOMAS</u>		14. MOTHER'S MAIDEN NAME <u>HATTIE L. HUDSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>221-22-3655</u>	
17. INFORMANT <u>ELIZABETH THOMAS FRANKFORD Del.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William R. Ellis</u> M.D.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>4-21-59</u>	
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>4/24/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Redmens, Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>DAGSBORO Del.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson & Gray</u>		ADDRESS <u>Frankford Del.</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

RECEIVED
JAN 10 1951

1951

CERTIFICATE OF DEATH

01316

1. Name of deceased: James Earl Ray

2. Date of death: April 4, 1968

3. Place of death: Memphis, Tennessee

4. Cause of death: Shot

5. Signature of physician: [Signature]

6. Signature of registrar: [Signature]

7. Signature of informant: [Signature]

8. Date of registration: April 10, 1968

9. Place of registration: Memphis, Tennessee

10. Registrar's name: [Name]

11. Registrar's address: [Address]

12. Registrar's phone: [Phone]

13. Registrar's fax: [Fax]

14. Registrar's email: [Email]

15. Registrar's website: [Website]

16. Registrar's social media: [Social Media]

17. Registrar's other information: [Other Information]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4952

Item 2 see birth cert.

CERTIFICATE OF DEATH

04947

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> <u>Accomack</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury/ Horntown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GENINSULA GENERAL Hospital</u>		d. STREET ADDRESS <u>83X-3</u>	
3. NAME OF DECEASED (Type or print) <u>Robert</u> First <u>Whitney</u> Middle <u>TOWNSEND</u> Last		4. DATE OF DEATH <u>April</u> Month <u>4</u> Day <u>4</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 3, 1959</u>
9. AGE (In years last birthday) yrs. <u>5</u>		10. IF UNDER 1 YEAR Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. <u>5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Townsend</u>		14. MOTHER'S MAIDEN NAME <u>Willie // // // Nellie Sally Pitts</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>James Townsend</u>		Address <u>Horntown, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Hemorrhage, see 7620</u> DUE TO (b) <u>Cerebral Anoxia due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Intrauterine anoxia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>12 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Heinrich Rohls</u> M.D.		ADDRESS (Street, city or town, state) <u>Berlin, Md.</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/14/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Horntown, Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Horntown, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u> ADDRESS <u>New Church, Va.</u>		24a. REC'D BY REGISTRAR <u>APR 10 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Head</u>			

2082261XV4

AGES

DECLARATION OF DEATH

12



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4953 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04948

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Md.</u>		c. LENGTH OF STAY IN 1b <u>16 hrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Parsonsburg</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pine Bluff State Hospital</u>			d. STREET ADDRESS <u>/</u>		
3. NAME OF DECEASED (Type or print) <u>Frank Lee Truitt</u>			4. DATE OF DEATH Month <u>April</u> Day <u>3</u> Year <u>19 59</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/17/1926</u>		9. AGE (In years last birthday) <u>33</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Minos Edward Truitt</u>			14. MOTHER'S MAIDEN NAME <u>Elsie Mae Dennis</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-26-3390</u>		17. INFORMANT Address <u>Records of Pine Bluff State Hospital</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO (b) <u>Pulmonary tuberculosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>year</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Earl L. Royer</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>4-3-59</u>		
EXAMINER'S NAME (Type) <u>Earl L. Royer</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Riverside Cem</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna R. Aubrey</u>		ADDRESS <u>Berlin Md.</u>		24a. REC'D BY REGISTRAR DATE <u>APR 7 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		24c. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

4954

CERTIFICATE OF DEATH

04949

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Vernon Lee TYNES</u>		4. DATE OF DEATH <u>April 14th 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 4, 1920</u>
9. AGE (In years last birthday) <u>38</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pump tender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Oscar H. Tynes</u>		14. MOTHER'S MAIDEN NAME <u>Isabella Turlington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-16-1557</u>	
17. INFORMANT <u>Helia Tynes - Fruitland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Essential Hypertension</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/12</u> , 19 <u>59</u> , to <u>4/14</u> , 19 <u>59</u> , that I lost saw the deceased alive on <u>4/13/59</u> , 19 <u>59</u> , and that death occurred at <u>7 A</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>4/14/59</u>	
ACTUAL SIGNATURE <u>R.C. Mitchell</u> M.D.		PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Remo-Burial 4-10-59</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Exmore, Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Edgar Thomas Oceanac, Va.</u>		24a. REC'D BY REGISTRAR <u>APR 20 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of birth: _____

5. Place of birth: _____

6. Date of death: _____

7. Place of death: _____

8. Cause of death: _____

9. Signature of physician: _____

10. Signature of registrar: _____

4955

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA General Hospital</u>				d. STREET ADDRESS <u>PHILADELPHIA AVE</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM FRANK TYRE</u>				4. DATE OF DEATH Month - Day Year <u>APRIL 27 19 59</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 2, 1879</u>		9. AGE (In years lost birthday) <u>80</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED ENGINEER RAILROAD</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>WICOMICO Co. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JOHN TYRE</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH WILLIAMS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>NO</u>			
17. INFORMANT <u>Mrs. W. F. Tyre</u>				Address <u>OCEAN CITY MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>4-14</u> , 19 <u>59</u> , to <u>4-27</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>4-27</u> , 19 <u>59</u> , and that death occurred at <u>5:45</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <u>William A. Ellis</u> M.D.							
PHYSICIAN'S NAME (Type) _____							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/30/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BELVIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burbyce</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 1 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanna</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1955

CERTIFICATE OF DEATH

1955

1

4956 Maryland State Department of Health—BALTIMORE, 18 Information taken from birth Cert. et CERTIFICATE OF DEATH

04951
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Berlin</u> <u>23X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u>		d. STREET ADDRESS <u>P. O. Box 202</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WAPLES</u>		4. DATE OF DEATH Month Day Year <u>APRIL 17 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 15, 1959</u>
9. AGE (In years last birthday) <u>9</u>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Harrison Earl / Waples</u>		14. MOTHER'S MAIDEN NAME <u>Lois Lorraine Worthington</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Address <u>Earl Waples Berlin Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity (Birthwt 610 gms)</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>April 15, 1959</u> , to <u>April 17, 1959</u> , that I last saw the deceased alive on <u>April 17, 1959</u> , and that death occurred at <u>4:20 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Agnes C. Koller</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>4/17/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>evergreen</u>	22d. LOCATION (City, town, or county) (State) <u>Berlin Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Clinton H. Stuart Salisbury Md</u>		24a. REC'D BY REGISTRAR <u>DATE APR 22 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained in the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1851

CERTIFICATE OF DEATH

1851



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1851

4957

CERTIFICATE OF DEATH

04952

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>23x-2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>(Ironshire) RFD</u>			
3. NAME OF DECEASED (Type or print) <u>Ernest Warren</u>				4. DATE OF DEATH <u>April 6-1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 3, 1892</u>	
9. AGE (In years lost birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>SEWELL WARREN</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA HENDERSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>			
17. INFORMANT <u>MRS. ERNEST WARREN</u>				Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Mar. 24, 1959</u> to <u>April 6, 1959</u> that I last saw the deceased alive on <u>April 6, 1959</u> , and that death occurred at <u>11:30 AM</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Schumacher</u>				ADDRESS (Street, city or town, state) <u>Salisbury Md April 6, 1959</u>			
PHYSICIAN'S NAME (Type) <u>David J. Schumacher</u>				DATE SIGNED <u>April 6, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/8/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Archie A. Burboys</u>				ADDRESS <u>Berlin Md</u>		24a. REC'D BY REGISTRAR <u>APR 10 1959</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur S. [Signature]</u>	

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1937

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
4958
CERTIFICATE OF DEATH

04953
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>23 X - 2</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>				d. STREET ADDRESS <u>BERLIN</u>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARY ETHEL WARREN</u>				4. DATE OF DEATH Month Day Year <u>April 15 1959</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 8, 1896</u>			
9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRACTICAL NURSE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SELF EMPLOYED</u>		11. BIRTHPLACE (State or foreign country) <u>BERLIN MD</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>									
13. FATHER'S NAME <u>GEORGE EVANS</u>				14. MOTHER'S MAIDEN NAME <u>MARY BAKER</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>No</u>					
17. INFORMANT Address <u>MR. LEE WARREN BERLIN MD</u>									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>343X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Encephalitis - Cause Undetermined</u> DUE TO (c) <u>26 days</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)									
21. I certify that I attended the deceased from <u>March 20, 1959</u> to <u>April 15, 1959</u> , that I last saw the deceased alive on <u>April 15, 1959</u> , and that death occurred at <u>6 P. M.</u> from the causes and on the date stated above.									
ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Prine Bluff Road Salisbury, MD</u>					
DATE SIGNED <u>4/15/59</u>									
PHYSICIAN'S NAME (Type) <u>Thomas C. Hill, Jr.</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/25/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. BURBAGE</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>APR 20 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carlton S. House</u>			

11408

CERTIFICATE OF DEATH

11408

[Faint, mostly illegible text from a death certificate form, including fields for name, date, and cause of death.]

1
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 4959
 CERTIFICATE OF DEATH

04954

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SOMERSET</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>DEAL ISLAND 19X-2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>		d. STREET ADDRESS <u>MAIN ROAD</u>	
3. NAME OF DECEASED (Type or print) <u>Roy</u> First <u>E.</u> Middle <u>Webster</u> Last		4. DATE OF DEATH <u>April 9th</u> 19 <u>59</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 9-1898</u>
9. AGE (In years lost birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEAFOOD</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SEAFOOD PACKER</u>	11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JOHN W WEBSTER</u>	
14. MOTHER'S MAIDEN NAME <u>LOTTIE BENTON</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>Edelen Webster</u>		17. INFORMANT Address <u>Deal Island Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Acute Coronary Occlusion</u> DUE TO (b) <u>Congestive Heart Failure; Arrhythmia</u> DUE TO (c) <u>Arteriosclerotic Cardiovascular Dis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebrovascular Accident - 7 das</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 das</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3/26</u> 19 <u>59</u> to <u>4/9</u> 19 <u>59</u> that I lost saw the deceased alive on <u>4/9</u> 19 <u>59</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rufus S. Gardner</u> M.D.		ADDRESS (Street, city or town, state) <u>PINEBLUFF Rd. SALISBURY, Md</u> DATE SIGNED <u>4/9/59</u>	
PHYSICIAN'S NAME (Type) <u>RUFUSS S. GARDNER, JR.</u>		22d. LOCATION (City, town, or county) (State) <u>Deal Island Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>April 12, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. JOHN'S METH.</u>	22d. LOCATION (City, town, or county) (State) <u>Deal Island Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. G. Webster</u> ADDRESS <u>Deal Island Md</u>		24a. REC'D BY REGISTRAR <u>APR 14 59</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur S. [unclear]</u>

10-10-58

CERTIFICATE OF DEATH

11

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Race", "Date of Birth", "Date of Death", "Cause of Death", "Place of Death", "Signature", and "Date" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4960

CERTIFICATE OF DEATH

04955

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b 3 mos. 3 Da.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital				d. STREET ADDRESS 308 Hammond Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carrie Middle M. Last White				4. DATE OF DEATH Month April Day 11 Year 19 59			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 13, 1885	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None			10b. KIND OF BUSINESS OR INDUSTRY None			11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Deceased (Gordon White)				14. MOTHER'S MAIDEN NAME Sarah White Melson Deceased			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Mrs. Marion Hastings (Niece) Sal. Md. Hospital Records -- Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinoma 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ca of Colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Secondary Anemia							INTERVAL BETWEEN ONSET AND DEATH ? ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1/7/59 , 19__, to 4/11/59 , 19__, that I last saw the deceased alive on 4/11/59 , 19__, and that death occurred at 1:58A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED 4/11/59							
ACTUAL SIGNATURE Dr. V. Juerman				M.D. Salisbury, Maryland			
PHYSICIAN'S NAME (Type) V. Juerman, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 13, 1959		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR APR 15 59	
				24b. REGISTRAR'S SIGNATURE Conrad A. Thoms			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and must be kept on file within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

04956
Reg. Dist. No.

4961

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Dist. before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>1 week</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL Hospital</u>				d. STREET ADDRESS <u>OCEAN CITY Hwy</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>ETHEL BELE WILLIAMS</u>				4. DATE OF DEATH Month Day Year <u>April 8th 1959</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 3, 1911</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>NEWARK MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES H. WEBB</u>				14. MOTHER'S MAIDEN NAME <u>ROSA BELE RICHARDS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. (If yes, give war duplicate of service) <u>NO</u>		INFORMANT Address <u>MR. OTHO J. WILLIAMS BERLIN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO <u>Cerebral Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe Uterine Cervicitis & Endometritis</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>April 1, 1959</u> to <u>April 8, 1959</u> that I last saw the deceased alive on <u>April 8, 1959</u> , and that death occurred at <u>6 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>David J. Salmore</u> M.D.				ADDRESS (Street, city or town, state) <u>Salisbury Md</u> DATE SIGNED <u>April 8, 1959</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>4/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anne D. Burbo</u> ADDRESS <u>Berlin Md.</u>				24a. REC'D BY REGISTRAR <u>APR 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>	

1

2

1

082

01950

CHIEF OF BUREAU

1951

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4962

CERTIFICATE OF DEATH

04957

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>		c. LENGTH OF STAY IN lb <i>6 days</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X Nanticoke</i>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>082 PENINSULA General Hospital.</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) First Middle Last <i>WARE TRAVERS WILLING</i>		4. DATE OF DEATH Month Day Year <i>APRIL 25 1959</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/14/1902</i>
9. AGE (In years last birthday) <i>56</i> yrs.	IF UNDER 1 YEAR Months <i>10</i> Days <i>11</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Oyster packer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Seafood industry Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME <i>J. WARE WILLING</i>		14. MOTHER'S MAIDEN NAME <i>STELLA M. TRAVERS</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>INFORMANT</i> Address <i>Myra Eversman Willing, Nanticoke, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>446 X</i> DUE TO <i>Anemia</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <i>Nephrosclerosis</i> DUE TO <i>Essential Hypertension</i> (c) <i></i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 month</i> <i>3 yrs</i> <i>Unknown</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <i>11:15</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>David J. Gilmore</i> M.D. <i>Salisbury Md. 4/25/59</i> PHYSICIAN'S NAME (Type) <i>David J. Gilmore</i> ADDRESS <i>Salisbury, Maryland 4/25/59</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>4/28/59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Turners Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Nanticoke, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>C. J. Persch, Bivalve, Maryland</i>		24. REC'D BY REGISTRAR DATE <i>APR 28 '59</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hines</i>			

1911

CERTIFICATE OF DEATH

1911

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04958

4963

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b X Salisbury (Rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		d. STREET ADDRESS #23 Gordy Lane (R.D.#5) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NELLIE Middle CATHERINE Last WIMBROW		4. DATE OF DEATH Month APRIL Day 9th Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 14, 1901
9. AGE (In years last birthday) 57 yrs.		10. IF UNDER 1 YEAR Months 5 Days 14 Hours 11 Min.	11. IF UNDER 24 HRS. Months 5 Days 14 Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work at home		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) R.D.# Salisbury, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPHUS E. ADKINS		14. MOTHER'S MAIDEN NAME MARY CATHERINE BROWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Mr. John M. Wimbrow (Husband) R.D.#5 Gordy Lane (Box #23) Salisbury, Maryland	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Pancreatitis 587.0 DUE TO (b) with Secondary Acute Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Hepatitis		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchopneumonia		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 8, 1959 to April 9, 1959 , that I last saw the deceased alive on April 9, 1959 , and that death occurred at 11:58 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Apr. 10, 1959	
ACTUAL SIGNATURE David J. Gilmore M.D.		DATE SIGNED Apr. 10, 1959	
PHYSICIAN'S NAME (Type) Dr. David J. Gilmore		Medical Center - Salisbury, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 12/1959	
22c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		22d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND		24a. REC'D BY REGISTRAR APR 13 '59 DATE	
24b. REGISTRAR'S SIGNATURE Arthur L. Thomas			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 15
CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. DATE OF DEATH		5. TIME OF DEATH		6. PLACE OF DEATH	
7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BIRTH	
10. OCCUPATION		11. EDUCATION		12. RELIGION	
13. MARITAL STATUS		14. PREVIOUS MARRIAGES		15. PREVIOUS DEATHS	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF PHYSICIAN	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY		21. SIGNATURE OF JUDGE	
22. SIGNATURE OF CLERK		23. SIGNATURE OF REGISTRAR		24. SIGNATURE OF SHERIFF	
25. SIGNATURE OF SHERIFF		26. SIGNATURE OF SHERIFF		27. SIGNATURE OF SHERIFF	
28. SIGNATURE OF SHERIFF		29. SIGNATURE OF SHERIFF		30. SIGNATURE OF SHERIFF	
31. SIGNATURE OF SHERIFF		32. SIGNATURE OF SHERIFF		33. SIGNATURE OF SHERIFF	
34. SIGNATURE OF SHERIFF		35. SIGNATURE OF SHERIFF		36. SIGNATURE OF SHERIFF	
37. SIGNATURE OF SHERIFF		38. SIGNATURE OF SHERIFF		39. SIGNATURE OF SHERIFF	
40. SIGNATURE OF SHERIFF		41. SIGNATURE OF SHERIFF		42. SIGNATURE OF SHERIFF	
43. SIGNATURE OF SHERIFF		44. SIGNATURE OF SHERIFF		45. SIGNATURE OF SHERIFF	
46. SIGNATURE OF SHERIFF		47. SIGNATURE OF SHERIFF		48. SIGNATURE OF SHERIFF	
49. SIGNATURE OF SHERIFF		50. SIGNATURE OF SHERIFF		51. SIGNATURE OF SHERIFF	
52. SIGNATURE OF SHERIFF		53. SIGNATURE OF SHERIFF		54. SIGNATURE OF SHERIFF	
55. SIGNATURE OF SHERIFF		56. SIGNATURE OF SHERIFF		57. SIGNATURE OF SHERIFF	
58. SIGNATURE OF SHERIFF		59. SIGNATURE OF SHERIFF		60. SIGNATURE OF SHERIFF	
61. SIGNATURE OF SHERIFF		62. SIGNATURE OF SHERIFF		63. SIGNATURE OF SHERIFF	
64. SIGNATURE OF SHERIFF		65. SIGNATURE OF SHERIFF		66. SIGNATURE OF SHERIFF	
67. SIGNATURE OF SHERIFF		68. SIGNATURE OF SHERIFF		69. SIGNATURE OF SHERIFF	
70. SIGNATURE OF SHERIFF		71. SIGNATURE OF SHERIFF		72. SIGNATURE OF SHERIFF	
73. SIGNATURE OF SHERIFF		74. SIGNATURE OF SHERIFF		75. SIGNATURE OF SHERIFF	
76. SIGNATURE OF SHERIFF		77. SIGNATURE OF SHERIFF		78. SIGNATURE OF SHERIFF	
79. SIGNATURE OF SHERIFF		80. SIGNATURE OF SHERIFF		81. SIGNATURE OF SHERIFF	
82. SIGNATURE OF SHERIFF		83. SIGNATURE OF SHERIFF		84. SIGNATURE OF SHERIFF	
85. SIGNATURE OF SHERIFF		86. SIGNATURE OF SHERIFF		87. SIGNATURE OF SHERIFF	
88. SIGNATURE OF SHERIFF		89. SIGNATURE OF SHERIFF		90. SIGNATURE OF SHERIFF	
91. SIGNATURE OF SHERIFF		92. SIGNATURE OF SHERIFF		93. SIGNATURE OF SHERIFF	
94. SIGNATURE OF SHERIFF		95. SIGNATURE OF SHERIFF		96. SIGNATURE OF SHERIFF	
97. SIGNATURE OF SHERIFF		98. SIGNATURE OF SHERIFF		99. SIGNATURE OF SHERIFF	
100. SIGNATURE OF SHERIFF		101. SIGNATURE OF SHERIFF		102. SIGNATURE OF SHERIFF	

